STATE OF MICHIGAN

DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

Before the Director of the Department of Insurance and Financial Services

In the matter of:

Physical Rehabilitation Services
Petitioner **File No. 21-1789**

v

Auto Club Insurance Association
Respondent

Issued and entered
this 3rd day of February 2022
by Sarah Wohlford
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On December 2, 2021, Physical Rehabilitation Services (Petitioner) filed with the Department of Insurance and Financial Services (Department) a request for an appeal pursuant to Section 3157a of the Insurance Code of 1956 (Code), 1956 PA 218, MCL 500.3157a. The request for an appeal concerns the determination of Auto Club Insurance Association (Respondent) that the Petitioner overutilized or otherwise rendered or ordered inappropriate treatment, products, services, or accommodations under Chapter 31 of the Code, MCL 500.3101 to MCL 500.3179.

The Petitioner's appeal is based on the denial of a bill pursuant to R 500.64(3), which allows a provider to appeal to the Department from the denial of a provider's bill. The Respondent issued the Petitioner bill denials on August 2 and 3, 2021. The Petitioner now seeks reimbursement in the full amount it billed for the dates of service at issue.

The Department accepted the request for an appeal on December 3, 2021. Pursuant to R 500.65, the Department notified the Respondent and the injured person of the Petitioner's request for an appeal on December 14, 2021 and provided the Respondent with a copy of the Petitioner's submitted documents. The Respondent filed a reply to the Petitioner's appeal on December 27, 2021.

The Department assigned an independent review organization (IRO) to analyze issues requiring medical knowledge or expertise relevant to this appeal. The IRO submitted its report and recommendation to the Department on January 18, 2022.

II. FACTUAL BACKGROUND

This appeal concerns the denial of payment for physical therapy treatments rendered on 11 dates of service[1] under procedure codes 97110, 97112, and 97140, which are described as therapeutic exercise, neuromuscular reeducation, and manual therapy, respectively. In its denial, the Respondent referenced American College of Occupational and Environmental Medicine (ACOEM) and determined that the "quantity of therapy has exceeded the ACOEM guideline recommendations for all regions documented" and "no reimbursement for additional physical therapy is recommended."

With its appeal request, the Petitioner provided documentation which identified the injured person's diagnoses as low back pain and traumatic spondylopathy of the lumbar region following a March 1991 motor vehicle accident (MVA). The Petitioner stated in its supporting documentation that the injured person's progression of symptoms "has resulted in severe limitations with ambulation, selfcare, home care, and worsening of neurological symptoms." The Petitioner further stated:

> The benefits of continued physical therapy include, but are not limited to, maintaining lumbosacral spine functional mobility, treatment of the lumbar spine multilevel facet joint dysfunction & associated lower extremity radiculopathy, and the management of chronic symptoms causing loss of function with activities of daily living.

In its reply, the Respondent reaffirmed its position and referenced ACOEM and the Official Disability Guidelines (ODG) in support. Specifically, the Respondent stated that the "medical records do not support this request as well over 70 physical therapy treatments [that] have been documented as provided." The Respondent also noted:

> Per the documentation, subjective reports of "low back pain, with spasms," and "improved spinal mobility with physical therapy," are noted ongoing. The physical therapy treatment quantity well exceeds the ACOEM and ODG recommendation guidelines, as per history it appears that physical therapy treatment has been ongoing with little to no interruption since 4/8/2019. Significant opportunity has been given to initiate and reinforce an independent, therapeutic, exercise, program to be done at home.

III. ANALYSIS

Director's Review

Under MCL 500.3157a(5), a provider may appeal an insurer's determination that the provider overutilized or otherwise rendered inappropriate treatment, products, services, or accommodations, or

[1] The dates of service at issue are July 5, 7, 9, 12, 14, 16, 19, 21, 23, 26, and 28, 2021.

that the cost of the treatment, products, services, or accommodations was inappropriate under Chapter 31 of the Code. This appeal involves a dispute regarding inappropriate treatment and overutilization.

The Director assigned an IRO to review the case file. In its report, the IRO reviewer concluded that, based on the submitted documentation, medical necessity was not supported on the dates of service at issue and the treatment was overutilized in frequency or duration based on medically accepted standards.

The IRO reviewer is a licensed doctor of physical therapy. In its report, the IRO reviewer referenced R 500.61(i), which defines "medically accepted standards" as the most appropriate practice guidelines for the treatment provided. These may include generally accepted practice guidelines, evidence-based practice guidelines, or any other practice guidelines developed by the federal government or national or professional medical societies, boards, and associations. The IRO reviewer relied on practice guidelines from the American College of Occupational and Environmental Medicine (ACOEM) for low back disorders and Official Disability Guidelines (ODG) for Auto Injury for its recommendation.

The IRO reviewer opined that medical necessity for the therapy treatments rendered cannot be established. Specifically, the IRO reviewer noted:

> ACOEM guidelines recommend 15 visits over 6 weeks for low back pain and ODG recommends 10-12 visits over 8 weeks. In this case, the [injured person] has attended over 70 sessions. This exceeds standard of care recommendations in quantity as well as elapsed time. While exceptions can be made for some additional treatment when comorbidities are a factor, there is no documentation of such health problems that would preclude the [injured person] from being transitioned to a home-care program.

The IRO reviewer recommended that the Director uphold the Respondent's determination that the treatment provided to the injured person on July 5, 7, 9, 12, 14, 16, 19, 21, 23, 26, and 28, 2021 was not medically necessary in accordance with medically accepted standards, as defined by R 500.61(i).

IV. ORDER

The Director upholds the Respondent's determinations dated August 2 and 3, 2021.

This order applies only to the treatment and dates of service discussed herein and may not be relied upon by either party to determine the injured person's eligibility for future treatment or as a basis for action on other treatment or dates of service not addressed in this order.

This is a final decision of an administrative agency. A person aggrieved by this order may seek judicial review in a manner provided under Chapter 6 of the Administrative Procedures Act of 1969, 1969 PA 306, MCL 24.301 to 24.306. MCL 500.244(1); R 500.65(7). A copy of a petition for judicial

review should be sent to the Department of Insurance and Financial Services, Office of Research, Rules, and Appeals, Post Office Box 30220, Lansing, MI 48909-7720.

Anita G. Fox
Director
For the Director:

X Sarah Wohlford

Sarah Wohlford
Special Deputy Director
Signed by: Sarah Wohlford